

9117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Law</u> Last <u>Arnt</u>		4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1932</u>
9. AGE (In years last birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTH PLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Roy Arnt</u>		14. MOTHER'S MAIDEN NAME <u>Kennie Mary Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If not, give war or dates of service)</u>	
17. INFORMANT <u>George R. Arnt, Jessup, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's Disease</u> 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1, 1957</u> to <u>Sept. 8, 1957</u> , that I last saw the deceased alive on <u>Sept. 8, 1957</u> , and that death occurred at <u>T.P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u>		DATE SIGNED <u>9/9/57</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>		ADDRESS (Street, city or town, state) <u>Savage, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert Donaldson</u>		24. REC'D BY REGISTRAR <u>11/1957</u>	
ADDRESS <u>Lanham</u>		24b. REGISTRAR'S SIGNATURE <u>Carol Shipley</u>	

CERTIFICATE OF DEATH

BUREAU V. 2

SEP 11 1957

RECEIVED

9097 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Q. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C. A. General</u>		d. STREET ADDRESS <u>141 Conduit</u>	
3. NAME OF DECEASED (Type or print) <u>Peter C. Apollo</u>		4. DATE OF DEATH Month <u>9-</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>With Unknown 1899</u>
9. AGE (In years lost birth day) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. LEGAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Funeral Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christos Apollo</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Nicholas J Madris</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X Aizotemia</u> DUE TO (b) <u>Nephritis, Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-20</u> , 19 <u>56</u> to <u>9-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-21</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST ANNAPOLIS, MD</u> DATE SIGNED <u>9/23/57</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St James Greek</u>	22d. LOCATION (City, town, or county) (State) <u>Q. A. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Evelyn Sons</u> ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>9/23/57</u> 24b. REGISTRAR'S SIGNATURE <u>J. D. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. S.

SEP 25 1957

RECEIVED

9098

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
c. LENGTH OF STAY IN 1b 10 Years		d. STREET ADDRESS 39 FRANKLIN STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH ANNAPOLIS, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEW Middle MORTON Last ATKINS		4. DATE OF DEATH Month Sept Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Sep 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Morton ATKINS		14. MOTHER'S MAIDEN NAME Maria Theresa KENNEDY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWI & WWII	
17. INFORMANT U.S. Naval Hospital, Annapolis, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMBOLISM, PULMONARY DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH One week 8 Mos. 3 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 September 19 57 to 3 September 19 57 , that I last saw the deceased alive on 3 September 19 57 , and that death occurred at 4:00A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		DATE SIGNED CDR HC USN U.S.N. Hosp. Anna. Md. 9-3-57	
PHYSICIAN'S NAME (Type) F. W. MEYER JR.		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Sept 5-57	22c. NAME OF CEMETERY OR CREMATORY Naval Academy	22d. LOCATION (City, town, or county) (State) Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		24a. REC'D BY REGISTRAR 9/4/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

BUREAU V. 3

SEP 6 1967

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY in 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1127 Old Annapolis Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest Floyd Baldwin</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28th</u> Year <u>19 57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/94</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhea County, Tennessee</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Driver's License.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/28/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>Nov. 10-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24a. REC'D BY REGISTRAR DATE <u>10/7/57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

RECEIVED

OCT 8 1957

BUREAU V. S.

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

FOR STATE
DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9119 CERTIFICATE OF DEATH

09107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCHTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHURCHTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CYNTHIA</u> Middle <u>ANN</u> Last <u>BLUNT</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 2 1957</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <u>1</u> Days <u>3</u> Hours <u>Weeks</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BLUNT, WILLIAM</u>		14. MOTHER'S MAIDEN NAME <u>ROSA LEE MACKELL BLUNT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>AAC HEALTH DEPT.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGENITAL HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>From Birth</u> <u>754.4</u> DUE TO <u>PROBABLY VALVULAR DEFORMITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEE AAC HEALTH DEPT. RECORDS</u> DUE TO (c) <u>SEE AAC HEALTH DEPT. RECORDS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mon</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>I didn't see body during 99 L. that I saw the deceased alive on Sept 26, 1957</u> , and that death occurred at <u>about 3:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Churchoon, Md.</u> DATE SIGNED <u>Oct 2 '57</u>			
ACTUAL SIGNATURE <u>F D Hendricks</u> M.D. <u>Shady side</u>		DATE SIGNED <u>Oct 2 '57</u>	
PHYSICIAN'S NAME (Type) <u>F D Hendricks</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>9-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Churchton</u>	22d. LOCATION (City, town or county) (State) <u>Churchoon, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese & Anna, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>Oct 2 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. Reese</u>

RECEIVED

OCT 3 1957

BUREAU V. 3.

CERTIFICATE OF DEATH

0910878

Reg. Dist. No.

9120

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne,	
c. LENGTH OF STAY IN b. 7mo. 7days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		d. STREET ADDRESS Box 266, Rt. 3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alex Middle Bounds Last Bounds		4. DATE OF DEATH Month 9 Day 2 Year 19 57	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Records		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized and Cerebral Arteriosclerosis DUE TO (c) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to September 2, 1957 , that I last saw the deceased alive on September 2, 1957 , and that death occurred at 10:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) DATE SIGNED Crownsville, Maryland 9-3-57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/3/57		22b. DATE OF DEATH 9/2/57	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones		24. REC'D BY REGISTRAR 9/4/57	
ADDRESS Princess Anne, Md		24b. REGISTRAR'S SIGNATURE K. M. Joyce	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 11

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09109 *24*

Reg. Dist. No.

9121

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna</i>		c. LENGTH OF STAY IN 1b <i>6/17/57</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Same</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Box 150 - Hwy 100 Rd</i>				d. STREET ADDRESS <i>Same</i>			
3. NAME OF DECEASED (Type or print) <i>Reuben Elsworth Bowen</i>				4. DATE OF DEATH Month <i>Sept.</i> Day <i>12</i> Year <i>1957</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <i>7/27/95</i>		9. AGE (In years last birthday) <i>62 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bar tender</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Co.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Edward Bowen</i>			
14. MOTHER'S MAIDEN NAME <i>Anna Chenoweth</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>218-01-79172</i>				17. INFORMANT <i>Bowen (same)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <i>0</i> a. m. <i>0</i> p. m. 19 <i>57</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED <i>9/12/57</i>			
22a. MANNER OF REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>14 Sept 1957</i>		22c. NAME OF CEMETERY OR CREMATOR <i>SATERS CEM</i>			
22d. LOCATION (City, town, or county) (State) <i>BALTO CO Md</i>		24a. REC'D BY REGISTRAR <i>SEP 16 1957</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rott & P. M. Wallace</i>				24b. REGISTRAR'S SIGNATURE <i>J. Keeling</i>			

MEDICAL CERTIFICATION

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AU

BUREAU V. S.

SEP 16 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 27

9122

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Odenton</u> <u>Odenton, Md.</u>		c. LENGTH OF STAY IN 1b <u>2 Months</u> <u>10 July 57</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u> <u>Anne Arundel</u>		c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Odenton</u> <u>Odenton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u> <u>Fort George G. Meade, Md.</u>						d. STREET ADDRESS <u>Dunrovin Trailer Park</u> <u>Dunrovin Trailer Park</u>					
3. NAME OF DECEASED (Type or print) <u>Michael William</u> <u>Charles</u>		First <u>Michael</u> Middle <u>William</u> Last <u>Bryan</u>		4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>1957</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>15 March 1953</u> <u>15 Mar 53</u>		9. AGE (In years last birthday) <u>4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTH PLACE (State or foreign country) <u>Fayette, N. C.</u> <u>Fayetteville, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A USA</u>		13. FATHER'S NAME <u>Charles L. Bryan</u>	
14. MOTHER'S MAIDEN NAME <u>Erna Marie Dietrich</u> <u>Dietrich, Erna Marie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Father, Dunrovin Trailer Park, Ft. Odenton</u> <u>Father, Charles L. Bryan - Dunrovin Trailer</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest - respiratory failure</u> <u>49-4</u> DUE TO <u>Fulminating pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right upper</u> <u>and middle lobes</u> DUE TO <u>middle lobes</u> (c) <u>middle lobes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4 Sept</u> 19 <u>57</u> , to <u>4 Sept</u> 19 <u>57</u> , that I last saw the deceased alive on <u>4 Sept</u> 19 <u>57</u> , and that death occurred at <u>2230</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Fort George G. Meade, Md.</u> DATE SIGNED <u>4 Sep 57</u>											
ACTUAL SIGNATURE <u>Capt. H. F. Farnsworth</u> M.D. <u>USAH, Fort George G. Meade, Md.</u>											
PHYSICIAN'S NAME (Type) <u>ARNOLD FIASCONE, Capt, MC</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/10/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>			
22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u>				22e. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u>				22f. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK INC. 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>5 Sep 57</u>				24b. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Capt. MSC</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09112

9099

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General				d. STREET ADDRESS South River Manor			
3. NAME OF DECEASED (Type or print) Crozia First Middle Last				4. DATE OF DEATH Sept. 6 Month Day Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ruffin Fuller				14. MOTHER'S MAIDEN NAME Marildia Hinton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Doyet Edward Bunn, Rt.1, Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Fall Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic since childhood.							INTERVAL BETWEEN ONSET AND DEATH 2 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient subject to frequent "black out" spells. regularly.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9 5 p. m. 19 57		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis, Anne Arundel, Md.		
21. I certify that I attended the deceased from Sept. 5, 1957 , to Sept. 6, 1957 , that I last saw the deceased alive on Sept. 5, 1957 , and that death occurred at 12:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jesse L. Wilkins M.D.				ADDRESS (Street, city or town, state) 98 Cathedral St.		DATE SIGNED Sept. 6, 1957	
PHYSICIAN'S NAME (Type) JESSE L. WILKINS, M.D.				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 8, 57		22c. NAME OF CEMETERY OR CREMATORY Hales Chapel		22d. LOCATION (City, town, or county) (State) Zebulon Johnston County, N.C	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR SEP 9 1957	
				24b. REGISTRAR'S SIGNATURE Mr. J. Henry			

RECEIVED

SEP 19 1954

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9123

CERTIFICATE OF DEATH

09113

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Underwood Road				d. STREET ADDRESS Underwood Rd.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM F BURGESS				4. DATE OF DEATH Month Day Year Sept 24 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 2, 1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (own farm)				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank P. Burgess				14. MOTHER'S MAIDEN NAME Soffie Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Edward Aisquith-Daughter- Riva, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 4hrs 10 years 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 19 46 , to Sept 24 19 57 , that I last saw the deceased alive on Sept 23 19 57 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED September 24, 1957							
ACTUAL SIGNATURE Edward G. Skerritt M.D.							
PHYSICIAN'S NAME (Type) Edward Skerritt MD				Gambrills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 27, 57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, A.A. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR SEP 27 1957	
24b. REGISTRAR'S SIGNATURE J. N. Joyce							

RECEIVED

SEP 24 1957

BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Abt. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 201</u>		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David Reid Calhoun</u>		4. DATE OF DEATH September 14th. 19 57	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/18</u>
9. AGE (In years last birthday) <u>38</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager of South Baltimore General Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>	
13. FATHER'S NAME <u>David Reid Calhoun</u>		14. MOTHER'S MAIDEN NAME <u>Laura Barbara ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>11 World War</u>		16. SOCIAL SECURITY NO <u>218-07-5074</u>	
17. INFORMANT <u>Mrs. Mary Ann Calhoun (wife)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED <u>9/14/57</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Conakowski</u>		24a. REC'D BY REGISTRAR <u>Clare Paschke</u>	
24b. REGISTRAR'S SIGNATURE <u>Clare Paschke</u>		DATE <u>SEP 19 1957</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Maryland Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

SEP 9 1947

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09115

9125

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>25 y.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 336, Route 2, Margate</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alice Kimball Chalker</u>				4. DATE OF DEATH <u>Septmebe 30th.</u> 19 <u>57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/26/75</u>		9. AGE (in years last birthday) <u>82</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rockland, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Amasa Kimball</u>			
14. MOTHER'S MAIDEN NAME <u>Beatrice Boyce</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>No</u>				17. INFORMANT Address <u>Mrs. Victor W. Volrath (daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular diseases</u> <u>440X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 y.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>47</u> , to <u>Sept. 30th.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/27/57</u> , and that death occurred at <u>11/20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>9/30/57</u> ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Floral Pk. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Binghamton, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes 130 E. Fort Ave. # 30</u>				24a. REC'D BY REGISTRAR DATE <u>10/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	

BUREAU Y. B.

101 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9100

CERTIFICATE OF DEATH

09116
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 440 Dewey Drive				e. STREET ADDRESS 440 Dewey Drive			
3. NAME OF DECEASED (Type or print) First ROLAND Middle F Last CHAMBERS				4. DATE OF DEATH Month September Day 27 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 6, 1908		9. AGE (In years last birthday) 49 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roland F. Chambers				14. MOTHER'S MAIDEN NAME Ursie J. Norfolk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 215 28 7381		17. INFORMANT Mrs. Virginia Chambers-Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) coronary artery disease (c) coronary artery disease						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 19, 1950 to Sept. 27, 1957 , that I last saw the deceased alive on 9/25/57 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Amos Garrett Blvd., Annapolis, Md. DATE SIGNED 9/28/57							
ACTUAL SIGNATURE S. Borssuck M.D.				ADDRESS Amos Garrett Blvd., Annapolis, Md.			
PHYSICIAN'S NAME (Type) S. Borssuck M.D.				ADDRESS Amos Garrett Blvd., Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 29, 57		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR SEP 30 1957	
				24b. REGISTRAR'S SIGNATURE Am. J. Lynch			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 1

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09117

9101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>A.A. Co. Hobbie Annapolis</i>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>A.A. Co General</i>		d. STREET ADDRESS <i>Annapolis Bridgewater Md</i>	
3. NAME OF DECEASED (Type or print) <i>Arthur Cole</i>		4. DATE OF DEATH <i>9-19-57</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown About 72 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Edward B. Cole</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT <i>Record of A.A. Co Home</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central Annuage</i> DUE TO <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>---</i> DUE TO (c) <i>---</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured Rt. Femur</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>p. m.</i> <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 1, 1957</i> to <i>Sept 18, 1957</i> , that I last saw the deceased alive on <i>Sept 18, 1957</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Maurice Klawans M.D.</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md</i>	
PHYSICIAN'S NAME (Type) <i>MAURICE F. KLANANS</i>		DATE SIGNED <i>9/20/57</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-21-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor SWS</i>		24a. REC'D BY REGISTRAR <i>---</i>	24b. REGISTRAR'S SIGNATURE <i>---</i>
ADDRESS <i>Annapolis Md</i>		DATE <i>9/23/57</i>	

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SEP 15 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09118

9126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		e. STREET ADDRESS <u>McKinsey Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora May DAY</u>		4. DATE OF DEATH Month Day Year <u>9-29 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bastville</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If not, give war or dates of service) <u>-</u>	
17. INFORMANT <u>Husband - George Day</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Mitral Stenosis</u> DUE TO (c) <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>9-29-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-28-57</u> , 19 <u>57</u> , and that death occurred at <u>9:45</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		DATE SIGNED <u>9-29-57</u>	
PHYSICIAN'S NAME (Type) <u>R. HAHN</u>		ADDRESS <u>Severna Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carpenters Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Severna Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/2/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John H. Hahn</u>			

BUREAU V. S.

OCT 9 1937

RECEIVED

9102

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>31- Canal Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER WILLIAM DORSEY</u>		4. DATE OF DEATH <u>September 3 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17, 1907</u>
9. AGE (In years last birthday) <u>50</u>		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Easton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give way or date of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO <u>219-30-4077</u>	
17. INFORMANT <u>Milton Dorsey (SON)</u>		Address <u>31- Canal St Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis due to Intestinal Obstruction</u> DUE TO (b) <u>from a Volvulus</u> DUE TO (c) <u>due to Peritonitis + abdominal viscera of Adhesions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/3</u> , 19 <u>57</u> , to <u>9/3/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/3/57</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. E. Richardson</u>		ADDRESS (Street, city or town, state) <u>115-64-47 ST ANNAPOLIS, Md.</u>	
PHYSICIAN'S NAME (Type) <u>William Reese - Anna, Md.</u>		DATE SIGNED <u>9/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>NE Lendrie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Anna, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9/10/57</u>	24b. REGISTRAR'S SIGNATURE <u>Am J French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NO. 1

11 1957

RECEIVED
J. Edgar Hoover
U. S. Department of Justice
Washington, D. C. 20535
Nov 11 1957

9103

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>818 BOOCHER AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE W. EVANS</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 22 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 2, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOAT REPR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOAT REPR.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Evans</u>		14. MOTHER'S MARDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Corz I. EVANS</u>		Address <u># 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 MO</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 27</u> , 19 <u>57</u> , to <u>Sept 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 21</u> , 19 <u>57</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/23/57</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John N. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>9/23/57</u>
			24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 of 2 should be filed with the funeral director, by the funeral director, and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 of 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 25 1957
BUREAU V. S.

9127

CERTIFICATE OF DEATH

09121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Alle Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alle Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		c. LENGTH OF STAY IN 1b <u>29 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box #1 Ridge Road</u>		d. STREET ADDRESS <u>Box #7 Ridge Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE A. FISHER</u>		4. DATE OF DEATH Month Day Year <u>SEPT 10, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1829</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Blandon, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Meyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-36-4138</u>	
17. INFORMANT <u>Mrs. Edna L. Fisher</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary atherosclerosis</u> DUE TO (b) <u>coronary atherosclerosis</u> DUE TO (c) <u>diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1948</u> to <u>Sept 10, 1957</u> , that I last saw the deceased alive on <u>Sept 10, 1957</u> , and that death occurred at <u>8:22 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.		DATE SIGNED <u>9/11/57</u>	
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		<u>Edwards 27 md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cen.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael J. Szyto</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Carol Aschupp</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 16 1957
BUREAU V. S.

9128

CERTIFICATE OF DEATH

091222

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Children's Center Hospital Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel, Md. c. LENGTH OF STAY IN 1b 15 months d. NAME OF HOSPITAL (If not in hospital, give street address) Children's Center Hospital		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1634 R Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Vessie Middle Gill Last Gill		4. DATE OF DEATH Month September Day 30 Year 1957	
5 SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1955
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	11 BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME Hazel Gill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -	
16. SOCIAL SECURITY NO. -		17. INFORMANT Children's Center Address Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial pneumonia 480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital osteogenesis imperfecta		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 0 p. m. 0	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/21/ 19 56 , to 9/30/ 19 57 , that I last saw the deceased alive on 9/30/ 19 57 , and that death occurred at 9:20P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.		ADDRESS (Street, city or town, state) Children's Center, Laurel, Md.	
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.		DATE SIGNED 10/1/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 3-57	22c. NAME OF CEMETERY OR CREMATORY Childrens Center	22d. LOCATION (City, town, or county) (State) Laurel Md
23. FUNERAL DIRECTOR'S SIGNATURE Wilfred R. Ehrmantraut		24a. REC'D BY REGISTRAR DATE Oct 1-57	
24b. REGISTRAR'S SIGNATURE Theresa			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG220 9-23-57 e+

9129

CERTIFICATE OF DEATH

09123

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A.A.</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>A.A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brocklyn</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brocklyn</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>118 Edgemoor Rd</i>				STREET ADDRESS (If rural give location) <i>118 Edgemoor Rd</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Elizabeth</i> (Middle) <i>A.</i> (Last) <i>Happel</i>				(Month) <i>9</i> (Day) <i>14</i> (Year) <i>57</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>A</i>	8. DATE OF BIRTH <i>9-11-66</i>	9. AGE last birthday <i>91</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Bein</i>				14. MOTHER'S MAIDEN NAME <i>Family name</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Family name</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <i>Hypertensive cardiac vascular disease</i>						<i>14 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 13, 1943</i> , to <i>Sept 14, 1957</i> , that I last saw the deceased alive on <i>Sept 14, 1957</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Philip W. Keister</i>				ADDRESS (Street, city, town, state) <i>302 Paterson Ave Balto 25 Md</i>		DATE SIGNED <i>9/16/57</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		DATE THEREOF <i>9-17-57</i>		NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>		LOCATION (City, town, or county) (State) <i>Balto.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>John M. Keister</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>McClary Thomas</i>		ADDRESS	
DATE <i>SEP 17 1957</i>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be signed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
SEP 17
BUREAU V. S.

9:30

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side	c. LENGTH OF STAY IN 1b 6 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Hine Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Borston Last Harrison		4. DATE OF DEATH Month Sept. Day 24th Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Eng	10b. KIND OF BUSINESS OR INDUSTRY Electrical	11. BIRTHPLACE (State or foreign country) Washington DC	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Frank A Harrison		14. MOTHER'S MAIDEN NAME Emma J Borston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	16. SOCIAL SECURITY NO (If yes, give year or dates of service) None	17. INFORMANT Florence V. Harrison	Address Hine Drive Shady Side
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Cardiovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Several years (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-24 , 19 57 , to 1957 , that I last saw the deceased alive on Dead on Arrival , and that death occurred at 6:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Harry N. Jones M.D. Deale Md 9-24-57 PHYSICIAN'S NAME (Type) Harry N. Jones			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/57	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cem	22d. LOCATION (City, town, or county) (State) Coleman Manor, PG & C, MD
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co - RIVERDALE MD		24a. REC'D BY REGISTRAR DATE 9-24-57	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 14 1957

RECEIVED

9104

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>HILLARY</u> Last <u>HILLARY</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1873</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Hillary</u>		14. MOTHER'S MAIDEN NAME <u>Mary Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Henry Hillary - Anna, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accidents</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>39 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>July 8</u> , 19 <u>52</u> , to <u>Sept 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>57</u> , and that death occurred at <u>6:10</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D. <u>45 Franklin St. Annapolis, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-2-57</u>	
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>		DATE <u>10-2-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	22d. LOCATION (City, town, or county) (State) <u>Davidsonville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Anna, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Francis</u>	

BUREAU V. S.

OCT 8 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9131

Item 9 P11M3220 9-16-57 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tydings-On-Bay		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Paradise Ave.	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS Cape St. Claire	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VERNON L. HOUCK		4. DATE OF DEATH Month September Day 8 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1891
9. AGE (In years last birthday) 67 6/12		10. IF UNDER 1 YEAR Months 6 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Oil	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Martin William Houck		14. MOTHER'S MAIDEN NAME Louise Pauline Felger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.1		16. SOCIAL SECURITY NO 212-07-5651	
17. INFORMANT J. Lloyd Wilkinson-4622 Wilmslow Rd. # 10		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
(b) Myocardial Infarct			
(c) Drowning			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Drowned	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9/7/ 19 57 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) water		20f. (City or town) (County) (State) Tydings on Bay Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>		DATE SIGNED 9/9/57	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-57	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24b. REGISTRAR'S SIGNATURE <i>Mr. J. French</i>	
ADDRESS Ellsworth Armacost -4600 Liberty Hghts. Ave.		DATE SEP 11 1957	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal—and in any event within 72 hours after death.

U. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9132

CERTIFICATE OF DEATH

09127 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1mo, 26days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS 403 Aisquith Street			
3. NAME OF DECEASED (Type or print) First Middle Last Anna Doran Johnson				4. DATE OF DEATH Month Day Year 9-7- 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 83? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10b. KIND OF BUSINESS OR INDUSTRY ---			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Peter Doran				14. MOTHER'S MAIDEN NAME Sarah Francis Doran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Hospital Records Address Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Age, Arteriosclerosis (General)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-20- 19 57 , to 9-7- 19 57 , that I last saw the deceased alive on 9-7- 19 57 , and that death occurred at 10:05 a. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Maryland			
DATE SIGNED 9-9-57							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) sep 14		22b. DATE THEREOF sep 14		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Baker				ADDRESS 918 Broad Hill Ave		24a. REC'D BY REGISTRAR SEI	
				DATE 9-9-57		24b. REGISTRAR'S SIGNATURE H. M. Jones	

RECEIVED
SEP 16 1957
BUREAU V. S.

09128

CERTIFICATE OF DEATH

Reg. Dist. No.

9133

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jessup</u>		LENGTH OF STAY (On this place) <u>14 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jessup</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montevideo Road</u>				STREET ADDRESS (If rural give location) <u>Montevideo Road</u>			
3. NAME OF DECEASED (Type or Print) <u>MAGGIE L. LANCASTER</u>				4. DATE OF DEATH <u>September 3, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 11, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Jessup, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Marks</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Miss Bertha L. Lancaster Same as 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cancer of stomach</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 4</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General carcinoma of the</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial infarct 2 mo</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 36, 1936</u> , to <u>Sept 3, 1957</u> that I last saw the deceased alive on <u>Sept 3, 1957</u> , and that death occurred at <u>10:03</u> M., from the causes and on the date stated above. <u>9/5/57</u>							
ADDRESS (Street, city, town, state) <u>2744</u> DATE SIGNED <u>Richard T. Singleton</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 7/57</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		LOCATION (City, town, or county) (State) <u>Wash. Blvd. Md.</u>	
24. REC'D BY REGISTRAR <u>P. G. 1957</u>		REGISTRAR'S SIGNATURE <u>Carroll Phelps</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard T. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

SEP 11 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 7 yrs. 2 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.	
f. STREET ADDRESS 39 Cathedral Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W.. Last Langford		4. DATE OF DEATH Month September Day 20 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/14/07
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Railroad		10b. KIND OF BUSINESS OR INDUSTRY Farmer & Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. & Langford		14. MOTHER'S MAIDEN NAME Eleanor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 262-22-1890	
17. INFORMANT Hospital Records		Address Crownsville, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 5610 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Paralytic Ileus DUE TO (c) Incarcerated right Inguinal Hernia INTERVAL BETWEEN ONSET AND DEATH Known to us since 11/22/49			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 22 , 19 49 , to Sept. 20 , 19 57 , that I last saw the deceased alive on Sept. 20 , 19 57 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/23/57 ACTUAL SIGNATURE [Signature] PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/25/57	Harwoodville	Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hucks		24. REC'D BY REGISTRAR DATE 9/25/57	24b. REGISTRAR'S SIGNATURE [Signature]

RECEIVED

SEP 27 1957

BUREAU V. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9105

CERTIFICATE OF DEATH

09130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE where deceased lived (If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>418 Severn Ave</i>		d. STREET ADDRESS <i>418 Severn Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Harvey</i> Middle <i>Mason</i> Last <i>Mason</i>		4. DATE OF DEATH Month <i>9</i> - Day <i>9</i> - Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 27 - 1877</i>
9. AGE (In years last birthday) <i>79</i> yrs		IF UNDER 1 YEAR: Months <i>7</i> Days <i>9</i> Hours <i>15</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boat Bld.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boat Builder</i>	
11. BIRTHPLACE (State or foreign country) <i>Deale Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Edward F. Mason</i>		14. MOTHER'S MAIDEN NAME <i>Anna Dougherty</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <i>—</i>	
17. INFORMANT <i>William H. Mason</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Cancer of prostate</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month <i>9</i> , Day <i>19</i> , Year <i>1957</i> Hour <i>a. p.</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3:00</i> to <i>4:30</i> , <i>1957</i> , that I last saw the deceased alive on <i>9-5</i> , <i>1957</i> , and that death occurred at <i>4:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D.		ADDRESS (Street, city or town, state) <i>63 College Ave</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>		DATE SIGNED <i>9-11-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-12-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St James</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>9/11/57</i>	
24b. REGISTRAR'S SIGNATURE <i>—</i>		25. REGISTRAR'S SIGNATURE <i>—</i>	

BUREAU V. S.

SEP 13 1987

RECEIVED

9106

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If none in hospital, give street address) OR INSTITUTION <i>A. A. General</i>		d. STREET ADDRESS <i>1009 Monroe St</i>	
3. NAME OF DECEASED (Type or print) <i>Nellie K. Medford</i>		4. DATE OF DEATH Month <i>9</i> Day <i>23</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-18-1880</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>AA Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Wilson Wells</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Brashears</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Harry J. Medford</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 4. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9/23</i> , 1957, to <i>9/23</i> , 1957, that I last saw the deceased alive on <i>9/23</i> , 1957, and that death occurred at <i>10:00</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Hildebrand</i>		ADDRESS (Street, city or town, state) <i>68 Franklin St. Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Annapolis, Md.</i>		DATE SIGNED <i>9/23/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-26-1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>9/26/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. French</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

SEP 1 1937

RECEIVED

9135 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Germany</u> b. COUNTY <u>Bavaria</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>2 da 10 hr 35 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KAREN ADDIE ELIZABETH MILES</u>				4. DATE OF DEATH Month Day Year <u>September 19 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 September 1957</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>10 55</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cecil Byron Miles</u>				14. MOTHER'S MAIDEN NAME <u>Margarete Schober</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Father, 1731 B Forrest Avenue, Fort Meade, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Focal atelectasis of both lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Possibly Hyaline membrane disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>2 da 10 hr 55 min</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>16 Sept. 1957</u> to <u>19 Sept. 1957</u> that I last saw the deceased alive on <u>19 Sept. 1957</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAH, Ft. G. G. Meade, Md.</u> <u>19 Sept 1957</u>							
ACTUAL SIGNATURE <u>Thomas A. Cook, Jr.</u> M.D. <u>USAH, Ft. G. G. Meade, Md.</u>							
PHYSICIAN'S NAME (Type) <u>THOMAS A. COOK, JR., MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook, Inc. 1217 St. Paul St.</u>				24a. REC'D BY REGISTRAR DATE <u>19 Sep 57</u>		24b. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr.</u>	

BUREAU V. S.

SEP 20 1900

THE CLEVELAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9136

Reg. Dist No.

24

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sylvan Shores, Riva

c. LENGTH OF STAY IN 1b

5 minutes

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Seymour River / South River

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

STATE Maryland

COUNTY A.A.

e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riva

d. STREET ADDRESS

Sylvan Shores

e. RESIDENT ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Donald Andrew Morris

4. DATE OF DEATH

Month

Day

Year

September 15th. 1957 19

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5/30/49

9. AGE (In years last birthday)

8 yrs

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attending school

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Prince George County, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert C. Morris

14. MOTHER'S MAIDEN NAME

Elizabeth Pyles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

None

17. INFORMANT

Address

Mr. and Mrs. R.C. Morris, (parents)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Accidental Drowning

424.8

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Jumped in the river and failed to come back to the surface.

20c. TIME OF INJURY

Month, Day, Year

3:45 p.m. 9/15/57 19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)

South River

20f. (City or town)

Riva, A.A. Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

Gustave H. Faubert

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/15/57

22a. BURIAL CREMATION, REMOVAL (S) (f)

Burial

22b. DATE THEREOF

9/17/57

22c. NAME OF CEMETERY OR GROUND

George Washington

22d. LOCATION (City, town, or county)

Hyattsville Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE 19 1957 L. J. Adkins

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOONAU V. B.

SEP 11 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11M3. Page 5 may be retained for file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09134

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side c. LENGTH OF STAY IN 1b 62 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE md b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle Nick Last 4. DATE OF DEATH Month Sept. Day 11th Year 1957		5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb 18, 1895 9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME W. JAMES Gross 14. MOTHER'S MAIDEN NAME Susan Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Marion Nick Address Shady Side, md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Hypertensive Cardiovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH 15 min 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Harry R. Jones EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried 4/1/57 22b. DATE THEREOF 4/1/57 22c. NAME OF CEMETERY OR CREMATORY St Matthews 22d. LOCATION (City, town, or county) (State) Shady Side, Md		23. FUNERAL DIRECTOR'S SIGNATURE J. B. Johnson ADDRESS Annapolis 24a. REC'D BY REGISTRAR SEP 17 '57 24b. REGISTRAR'S SIGNATURE W. H. Smith	

MEDICAL CERTIFICATION

BUREAU V. S.

SEP 17 1957

RECEIVED

CERTIFICATE OF DEATH

Item 9. Film G221 32/3/57. for

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Epping Forest</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A. C. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Nickerson</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Confectioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Confectioner</u>	
11. BIRTHPLACE (State or foreign country) <u>Millington Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John R. Nickerson</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Campbell Simpson</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CORONARY DISEASE</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>57</u> , to <u>9/13</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>9/13</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund Sheek</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave Annapolis Md</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>9/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Hallows Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Darlingtonville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>9/17/57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

9138

CERTIFICATE OF DEATH

09136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Shore Acce Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> <u>Noonan</u>		4. DATE OF DEATH Month Day Year <u>9</u> <u>22</u> <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7, 1886</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Lowell Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Noonan</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>wife - Mrs. Noonan</u>		Address <u>Arnold, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Congestive Heart Failure</u> <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>57</u> , to <u>30</u> , 19 <u>57</u> that I last saw the deceased alive on <u>9-21-57</u> , 19 <u>57</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md.</u> DATE SIGNED <u>9-22-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		<u>Severna Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-24-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR <u>9/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>V. Ormick</u>	

RECEIVED

SEP 25 1957

BUREAU V. S.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page
4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A13ME
5M 2/57

Item 16 Film 221 10-1-57
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09137

9139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission). a. STATE <u>Same</u> COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Arnold</u>			c. LENGTH OF STAY IN 1b <u>5 y.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>600 Shore Shore Acres Rd.</u>			d. STREET ADDRESS <u>Same</u>		
3. NAME OF DECEASED (Type or print) <u>Hilda Jean Noonan</u>			4. DATE OF DEATH September 24th, 19 57		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1885</u>		9. AGE <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		10c. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
11. FATHER'S NAME <u>Thomas Jean Astell</u>			12. MOTHER'S MAIDEN NAME <u>Sadie G Lyons</u>		
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			14. SOCIAL SECURITY NO <u>Mr and Mrs. Elmer Smith (Neighbors)</u>		
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide (Cause is pending) caused by a mixture of drugs</u> 97 1 DUE TO in the blood, the identity could not be determined. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
16a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			16b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
17a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		17b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		17c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>?</u>	
17d. (City or town) <u>?</u>		17e. (County) <u>?</u>		17f. (State) <u>?</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 25th, 1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Sept 28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	
22d. LOCATION (City, town, or county) <u>Prince George Co</u>		22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md</u>			24a. REC'D BY REGISTRAR DATE <u>9/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

2

BUCHANAN V. S.

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RECEIVED

9140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
c. LENGTH OF STAY IN 1b <u>46 yrs.</u>				d. STREET ADDRESS <u>110 Glenvale Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Stevenson</u> Last <u>Oliver</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/11/76</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>57</u>		11. IF UNDER 24 HRS Hours <u>57</u> Min. <u>19</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Albany Co. N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Wm. Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Werner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Austin Oliver - same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Cervix</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 1941, to <u>9/13</u> , 19 <u>57</u> that I last saw the deceased alive on <u>9/13/57</u> , 19____, and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>9/13/57</u>							
ACTUAL SIGNATURE <u>Chas. L. Ball</u> M.D. <u>Linthicum</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, RE-INTERMENT (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 16/1957</u>		<u>Friendship Cemetery</u>		<u>Anne Arundel Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				DATE <u>9/17/57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0913978

9141

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>12 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKRIDGE Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSP</u>		d. STREET ADDRESS <u>BOX 131A</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>PAGE</u> Last <u>PAGE</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3, 1980</u>
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>THOMAS PAGE</u>		14. MOTHER'S MAIDEN NAME <u>SAKAH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO RECORD</u>	
17. INFORMANT <u>HOSPITAL RECORD</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UREMIA</u> 600.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PYELONEPHRITIS</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR D'S</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-10-1957</u> to <u>9-21-1957</u> , that I last saw the deceased alive on <u>9-21-1957</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. McGee</u> M.D.		ADDRESS (Street, city or town, state) <u>CROWNSVILLE STATE HOSP</u>	
PHYSICIAN'S NAME (Type) <u>JOHN J. MCGEE</u>		DATE SIGNED <u>9/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/25/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MCLAUGHLIN</u>	22d. LOCATION (City, town, or county) (State) <u>ELKRIDGE Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Williams</u>		24. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>322 H. Leachman St.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>9/24/57</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

25

9142

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PARK</u>				c. LENGTH OF STAY IN lb <u>37 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 9th AVE.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PARK</u>			
				d. STREET ADDRESS <u>108 9th AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>PARKER</u> Last <u>2 (PARKER)</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 3, 1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MISSISSIPPI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>ANTOINETTE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT Address <u>MRS. AGNES BARANOWSKI SAME</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>							
440.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiac vascular disease</u>							
DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>June 15, 1957</u> to <u>Sept 29, 1957</u> , that I last saw the deceased alive on <u>Sept 28, 1957</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Rubin</u> M.D.				ADDRESS (Street, city or town, state) <u>203 Patapsco Ave</u> DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL RUBIN MD</u>				<u>203 PATAPSCO AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		22d. LOCATION (City, town, or county) <u>RITCHIE Hwy AA Co., MD</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Foxe</u> ADDRESS <u>4001 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>9/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09142 28

9143 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry Ponger		4. DATE OF DEATH Month Day Year 9-8-1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 88 7/8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 88 7/8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME *****		14. MOTHER'S MAIDEN NAME *****	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO --- (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility and Malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to 9-8-1957 , that I last saw the deceased alive on 9-8-1957 , and that death occurred at 12:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9-9-57			
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Lionel McHenry Mapp, M. D.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-14-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Meth. Cem.		22d. LOCATION (City, town, or county) (State) Lanham, Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons		24a. REC'D BY REGISTRAR SEP 16 1957	
ADDRESS 467 N. St. Md.		24b. REGISTRAR'S SIGNATURE M. J. Jones	

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SEP 16 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09143

9108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
c. LENGTH OF STAY IN 1b 3hr. 20min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		d. STREET ADDRESS 95 Sellers Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle PORTER Last PORTER		4. DATE OF DEATH Month September Day 14 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 September 1957
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 0 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jon Marshall PORTER		14. MOTHER'S MAIDEN NAME Julia May HOWARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity and Immaturity 776 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3hrs. 20 M	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 14 September, 1957 , to 14 September, 1957 , that I last saw the deceased alive on 14 September 1957 , and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. NAVAL HOSPITAL 14 September 57			
ACTUAL SIGNATURE John J. Egan Jr.		PHYSICIAN'S NAME (Type) J. T. EGAN, Jr., CDR MC USN	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF 9-16-57	
22c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL ACADEMY		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		24a. REC'D BY REGISTRAR 9/17/57	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE O. Daniel	

BUREAU V. 8

SEP 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Mo.</u>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>F.A. GENERAL Hospt.</u>			d. STREET ADDRESS <u>25 FRANKLIN St.</u>		
3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>B.</u> Last <u>RECORD</u>			4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER</u>		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Willis RECORD</u>		
14. MOTHER'S MAIDEN NAME <u>LORINDA CAMPBELL</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give year or date of service) <u>W.W.I.</u>		
16. SOCIAL SECURITY NO. <u>W.W.I.</u>			17. INFORMANT <u>Sahlie M. RECORD</u> Address <u>#2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>975x</u> DUE TO <u>urinary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1</u> DUE TO <u>urinary</u> (c) <u>urinary</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>urinary</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>[Signature]</u>			DATE SIGNED <u>9/27/57</u>		
EXAMINER'S NAME (Type) <u>J. Linhardt</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis NATIONAL</u>	
22d. LOCATION (City, town or county) <u>Annapolis Mo.</u>		22e. LOCATION (City, town or county) <u>Mo.</u>		22f. LOCATION (City, town or county) <u>Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Taylor & Sons</u>			24a. REC'D BY REGISTRAR <u>10-30-57</u>		
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

U.S. DEPARTMENT OF JUSTICE

RECEIVED
JUL 1 1964

9110

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Melvin Rd.</u>		d. STREET ADDRESS <u>Melvin Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>O</u> Last <u>REDUE JR.</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-1868</u>
9. AGE (In years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN HENRY REDUE</u>	
14. MOTHER'S MAIDEN NAME <u>DEBORAH JONES</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>(If yes, give war or date of service)</u>		17. INFORMANT <u>HENRY O. REDUE JR.</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cerebrovascular Disease</u> DUE TO (c) <u>54125</u>			INTERVAL BETWEEN ONSET AND DEATH <u>54125</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>9/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/27/57</u> , 19 <u>57</u> , and that death occurred at <u>6</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LODON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>9/30/57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

187

187

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9144

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please
advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Nebraska</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>			c. LENGTH OF STAY IN 1b <u>1 hour</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sillery Bay</u>			d. STREET ADDRESS <u>721 South 42nd. Street</u>		
3. NAME OF DECEASED (Type or print) <u>Spencer Grady Richardson</u>			4. DATE OF DEATH Month <u>September</u> Day <u>3rd.</u> Year <u>19 57</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6/4/45</u>		9. AGE (in years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending school</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pasadena, California</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Colonel John B. Richardson Jr.</u>			
14. MOTHER'S MAIDEN NAME <u>Jeanne Farley Spencer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Colonel John B. Richardson (father)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to drowning</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell overboard from sailboat</u>			
20c. TIME OF INJURY Month, Day, Year <u>7 2 45</u> p.m. <u>4 3 19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Water</u>	
20f. (City or town) <u>Anne Arundel</u>		20g. (County) <u>Il.</u>		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R. B. [Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-11-57</u>	
EXAMINER'S NAME (Type) <u>R. B. [Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Va.</u>		22e. (State) <u>Il.</u>		22f. (Country)	
23. FORMAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
DATE <u>9/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>9/6/57</u>	

RECEIVED

SEP 10 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
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9145

CERTIFICATE OF DEATH

Reg. Dist. No.

09147 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Catherine Middle Scott Last		4. DATE OF DEATH Month September Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown to us		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suppurative Pyelonephritis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed Myocardial Infarct			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 13th, 19 57, to September 15, 19 57, that I last saw the deceased alive on Sept. 15th, 19 57, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 19, 57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis A. Hemmley		24. REC'D BY REGISTRAR DATE 9/15/57	
24b. REGISTRAR'S SIGNATURE J. M. Jager			

BUREAU V. S.

SEP 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9111

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A. C. General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sarah S. Sharps</u>				4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OF RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-1910</u>	9. AGE (In years last birthday) <u>46</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Sollars</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Lee Staters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-1948</u>		17. INFORMANT <u>William Sharps</u> Address <u>Anna, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mammary Carcinoma to chest</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>lymph nodes, Liver and Spleen</u> DUE TO (c) <u>Carcinoma of Stomach</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/14/57</u> , 19 <u>57</u> , to <u>9/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/15/57</u> , 19 <u>57</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Rich</u>				ADDRESS (Street, city or town, state) <u>M.D. R. L. RICHESON MD.</u> DATE SIGNED <u>9/17/57</u>			
PHYSICIAN'S NAME (Type) <u>William Seese, Jr. Anna, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		22d. LOCATION (City, town, or county) (State) <u>Bristol Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Seese, Jr. Anna, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>9/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

1. **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

RECEIVED

SEP 1957

BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09149

9112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH L. SLIDER</u>		4. DATE OF DEATH <u>9</u> Month <u>25</u> Day <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1915</u>
9. AGE (In years last birthday) <u>42</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN RENKO</u>		14. MOTHER'S MAIDEN NAME <u>ANNA ONDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ALONZO B. SLIDER</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>Hepatic coma.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Jaundice's Ceribacii</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u> <u>3 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-12</u> , 19 <u>57</u> , to <u>9-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-25</u> , 19 <u>57</u> , and that death occurred at <u>11:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Pelem</u> M.D.		ADDRESS (Street, city or town, state) <u>Franklin St.</u> DATE SIGNED <u>9-26-57</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEPAR BURY</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Giga + Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>9/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

BUFFALO N. Y.

1870

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

Items 18-21 Film 22-10-23-57
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09150

9146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>7yrs., 6mths.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Maryland</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital, Md.</u>				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Snowden</u> Last <u>Snowden</u>				4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/1876</u>	9. AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Snowden</u>				14. MOTHER'S MAIDEN NAME <u>India</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>		17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus due to fracture of Jaw</u> <u>983X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis. Emaciation.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Struck in jaw</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9/17/57</u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Crownsville Anne Arundel Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Paul F. Guerin</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Paul F. Guerin, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>	
				22d. LOCATION (City, town, or county) (State) <u>Clarksburg, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				24a. REC'D BY REGISTRAR <u>SEP 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. W. Fryer</u>	

BUREAU V. S.

SEP 1957

RECEIVED

Walt J. ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09151-8

9147

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		d. STREET ADDRESS <u>1315 East Biddle Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Stanley</u> Last <u>Stanley</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u>
9. AGE (In years last birthday) yrs. <u>64</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Caleb Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Annie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Syphilis. Mental Deficiency without Psychosis.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>about 10 days</u> <u>Known to us since 1/25/46</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that I attended the deceased from <u>January 25, 1946</u> , to <u>Sept. 30, 1957</u> , that I last saw the deceased alive on <u>Sept. 30, 1957</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>	
DATE SIGNED <u>9/30/57</u>		M.D. <u>Crownsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		<u>Crownsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>	22d. LOCATION (City, town, or county) (State) <u>A. D. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders</u>		ADDRESS <u>217 E. Preston St</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>10/2/57</u>			

BUREAU V. S.

NOT 0 1937

RECEIVED

9113

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				f. STREET ADDRESS 21 Eastern Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RENEE Middle RUTH Last STARBECKER				4. DATE OF DEATH Month SEPTEMBER Day 9 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1957	
9. AGE (In years last birthday) 0 yrs		10. IF UNDER 1 YEAR Months 1 Days 2 Hours Min. 		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
13. FATHER'S NAME Eugene Starbecker				14. MOTHER'S MAIDEN NAME Mavis Kennedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 				16. SOCIAL SECURITY NO. 			
17. INFORMANT Address Mrs Mavis Starbecker- Mother- Same as # 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Multiple Congenital Defects - including cleft lip. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cleft Palate, congenital malformation of, congenital heart etc - (b) (c) 						INTERVAL BETWEEN ONSET AND DEATH 4-5 days Present at birth -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 763.0						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) (County) (State) 							
21. I certify that I attended the deceased from 9 Aug , 19 57 , to 9 Sept , 19 57 , that I last saw the deceased alive on 8 Sept , 19 57 , and that death occurred at 4:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 95 Calverton St, Annapolis Md DATE SIGNED 9 Sept 57							
ACTUAL SIGNATURE Philip Briscoe				M.D. Philip Briscoe MD			
PHYSICIAN'S NAME (Type) Philip Briscoe MD				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11, 57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cem.		22d. LOCATION (City, town, or county) Annapolis, Maryland (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR SEP 13 1957 24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 10 1944

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09153

Reg. Dist. No.

9148

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Arnold Pasadena				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 65 Johnson Rd. Bar Harbor				e. STREET ADDRESS Same			
3. NAME OF DECEASED (Type or print) Walter William Stein				4. DATE OF DEATH September 23rd. 19 57			
5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/85	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		11. BIRTHPLACE (State or foreign country) Germany, Europe.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Oscar Stein				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-0471		17. INFORMANT Mrs. Anna Stein (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gustave H. Faubert				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
NAME (Type) Gustave H. Faubert, M.D.				DATE SIGNED September 24th. 1957.			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 25-57		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Catholic Hgwy		22d. LOCATION (City, town or county) (State) Brooklyn G A Co ind	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard G. Fink				24. REG. STRAR'S SIGNATURE Louis J. DeAlba			

RECEIVED

SEP 03 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09154

9:49

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE Maryland b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle W. Last Stewart				4. DATE OF DEATH Month 9 Day 9 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1916		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson J. Stewart				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Hospital Records Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio-respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Status Epilepticus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Paresis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-9- , 19 57 , to 9-9- , 19 57 , that I last saw the deceased alive on 9-9- , 19 57 , and that death occurred at 9:30 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 9-9-57							
ACTUAL SIGNATURE Lionel McHenry Mapp				M.D. Crownsville, Maryland			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Rural		22b. DATE THEREOF Sept 11 1957		22c. NAME OF CEMETERY OR CREMATORY Union Chapel		22d. LOCATION (City, town, or county) (State) Davidsonville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty				ADDRESS Galeville, Md		24a. REC'D BY REGISTRAR DATE 9/13/57	
				24b. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED
SEP 10 1967
BUREAU V. S.

9114 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>3 Kirkley Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS H. STINCHCOMB III</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 30 19 57</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1957</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas H. Stinchcomb Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Hilda E. Gosheff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mr. Thomas H. Stinchcomb Jr Father same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/29</u> , 19 <u>57</u> , to <u>9/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/30</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip Briscoe</u> M.D.				ADDRESS (Street, city or town, state) <u>95 Capital ST</u> DATE SIGNED <u>10/1/57</u>			
PHYSICIAN'S NAME (Type) <u>Philip Briscoe MD</u>				<u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>0013 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 of 7 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 3 1957

RECEIVED

9150

CERTIFICATE OF DEATH

09156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 2 Edgewood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oscar Middle W. Last Tilghman		4. DATE OF DEATH Month Sept. Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown (deceased)		14. MOTHER'S MAIDEN NAME Unknown (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 214-07-9501	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostate Bronchopneumonia, Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive and Arteriosclerotic Cardiovascular DUE TO Disease (c) Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcer of Buttocks, Arterial Hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 57 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from Sept. 29, 19 56 , to Sept. 15, 19 57 , that I last saw the deceased alive on Sept. 15, 19 57 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED -----			
ACTUAL SIGNATURE [Signature]		M.D. Crownsville State Hospital, Md.	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/57	
22c. NAME OF CEMETERY OR CREMATORY Wauchoke Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. M. Clair		ADDRESS 317 High St.	
24a. REC'D BY REGISTRAR [Signature]		24b. REGISTRAR'S SIGNATURE [Signature]	

RECEIVED

NOV 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09157

9151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundale</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A A Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>423 Ritchie Hgy</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Taylor</u> Middle <u>C Walston</u> Last <u></u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 1891</u>		9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leading Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U S Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>L uther Walston</u>				14. MOTHER'S MAIDEN NAME <u>Trisaney Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>705-05-9479</u>		17. INFORMANT Address <u>Freida W Walston 423 Ritchie Hgy Glen Burnie</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism And/or Myocardial Rupture</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Postero-lateral Myocardial Infarction</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>13 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u></u> Day <u>19</u> Year <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/25/57</u> 19 <u>57</u> , to <u>9/8/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/8/57</u> 19 <u>57</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leonard H. Flax</u> M.D.				ADDRESS (Street, city or town, state) <u>113 7th Ave Brooklyn Park</u>			
PHYSICIAN'S NAME (Type) <u>Leonard H. Flax M.D.</u>				DATE SIGNED <u>9/9/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Rd Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson</u>				ADDRESS <u>2359 Wash Blvd Balto 30 Md</u>		24a. RECEIVED BY REGISTRAR DATE <u>SEP 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. DeBlas</u>			

RECEIVED

SEP 11 1

BUREAU V. S.

9115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.P.C.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>GALESVILLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN'L</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>Weston</u>		4. DATE OF DEATH Month Day Year <u>SEPT.</u> <u>6</u> <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Halesville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Weston</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Duggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. F. ELIZABETH Weston</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malign. Cachexia Tumors</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>45</u> , to <u>9/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson Jr.</u>		ADDRESS (Street, city or town, state) <u>37 Calver St</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>		DATE SIGNED <u>9/2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	22d. LOCATION (City, town, or county) (State) <u>Halesville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O. Harduty</u>		24a. REC'D BY REGISTRAR <u>9/11/57</u>	
ADDRESS <u>Halesville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6-106

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BUREAU W. M.

SEP 13 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09159

9152

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 1 yr. 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 1217 N. Dallas Street	
3. NAME OF DECEASED (Type or print) First William Middle E. White Last		4. DATE OF DEATH September 23 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown to us		14. MOTHER'S MAIDEN NAME Unknown to us	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 026X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized and Cerebral Arteriosclerosis DUE TO (c) CNS Syphilis		INTERVAL BETWEEN ONSET AND DEATH Known to us since 9/21/56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 21, 19 56, to Sept. 23, 19 57, that I last saw the deceased alive on Sept. 23, 19 57, and that death occurred at 6:20 a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED 9/23/57	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 26/57	
22c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Edick		ADDRESS 1129 N. CAROLINE	
24a. REC'D BY REGISTRAR DATE 9/25/57		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10253**

9116

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 10 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Best Gate Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Best Gate Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAM Middle WILLIS Last WILLIS		4. DATE OF DEATH Month September Day 25 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 50 yrs.
9. AGE (In years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia. 490x DUE TO Conditions, if any, which gave rise to immediate cause (b) 490x (a), stating the underlying cause last. (c) 490x DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Paul F. Guerin M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 9/27/57
EXAMINER'S NAME (Type) Paul F. Guerin, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-22-57	
22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE 10/23/57	
24b. REGISTRAR'S SIGNATURE John J. French			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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BUREAU A. B.

Paul W. Davis